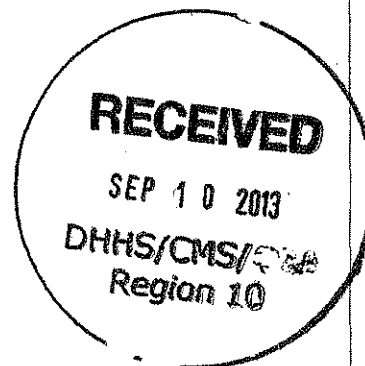


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505318	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/13/2013
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF SKAGIT VAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1462 WEST STATE ROUTE 20 SEDRO WOOLLEY, WA 98284		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey (QIS) conducted onsite August 5, 2013 through August 9, 2013 and August 12, 2013 through August 13, 2013. The phase two survey sample based on a resident census of 78 included 31 current residents, and 10 closed records of discharged residents.</p> <p>This survey was also a Federal QIS Comparative Survey of the unannounced QIS recertification survey conducted July 8, 2013 through July 12, 2013 by the Department of Social &amp; Health Services Aging &amp; Disability Services Administration Residential Care Services, Region 3, Unit B.</p> <p>The federal team members were: Barbara Daggy RN, Team Leader [REDACTED] RN</p> <p>Federal surveyors can be reached at: US Department of Health and Human Services CMS (Centers for Medicare and Medicaid Services) Region 10, MS RX - 48 2201 Sixth Avenue Seattle, WA 98121 206.615.2313 206.615.2088 (Fax)</p>	F 000	<p>F000</p> <p>This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of the plan does not constitute agreement by the facility that the surveyor's findings constitute deficiency, or that the scope or severity regarding any of the deficiencies cited is accurately applied.</p>		



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Cathie Klepper* Executive Director

9-6-13

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1	F 000			
F 279 SS=D	<p>Barbara Daggy RN, Team Leader 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop comprehensive care plans for two of 29 sampled residents (Resident #86 and #46) when Resident #86's pain care plan did not reflected hospice services and when Resident #46 did not have a care plan initiated for diuretic (a medication that helps reduce the amount of water in the body) use.</p>	F 279	<p>F279 1. Resident 46 and 86 no longer reside in the facility.</p> <p>2. Care plans for residents receiving Hospice services were reviewed with the Hospice Registered Nurse (RN) and updated as needed to ensure coordination of pain management.</p> <p>Care plans for residents receiving diuretics were reviewed and updated as needed.</p> <p>3. The DON met with Hospice management to develop a protocol for updating care plans. The Director of Nursing (DON) will re-educate the MDS nurses to coordinate care plan development with Hospice.</p> <p>The DON, Resident Care Managers (RCMs) and MDS nurses will develop care plans for residents taking diuretics. The DON will educate RCMs MDS and admission nurses to initiate</p>	9-24-13 ✓	

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F 279	<p>Continued From page 2</p> <p>Findings include:</p> <p>#1. Resident #86's medical record indicated the resident had diagnoses that included cancer ( ), which required chemotherapy, obstruction of the bile duct, dementia, difficulty walking, and Alzheimer's disease. A pain care plan was initiated on 5/6/13 related to cancer. The care plan indicated the resident had "cognitive deficits that could interfere with [the resident's] ability to report pain. The care plan interventions further indicated that nursing staff should:</p> <ul style="list-style-type: none"> <li>*administer and observe for the effectiveness of the pain medication</li> <li>*notify the resident's physician if the resident was unable to state or demonstrate relief or reduction of ain after one hour of receiving the first intervention</li> <li>*Certified Nursing Assistants (CNAs) should observe and report to nurse signs and symptoms of pain and/or worsening pain</li> <li>*Observe for signs and symptoms of constipation and administer bowel protocol as needed</li> <li>*Nursing staff should report changes in pain location, type, frequency, and intensity to physician.</li> </ul> <p>A Physician's Order dated 6/17/13 indicated that the family wanted the resident to be placed on hospice. The note also indicated that hospice would assess the resident on 6/17/13.</p> <p>The hospice agency initiated a care plan on 6/17/13 that indicated under pain status to "assess client's pain: description, duration, and intensity." The care plan indicated the resident was receiving the following pain medications:</p> <ul style="list-style-type: none"> <li>*acetaminophen 650 milligram (mg) rectally every</li> </ul>	F 279	<p>the diuretic care plan when orders are received.</p> <p>4. RCMs will audit care plans at least weekly for not less than 3 months for residents on Hospice to ensure coordination of care.</p> <p>RCMs will audit care plans for residents on diuretics to ensure appropriate care and services.</p> <p>The DON will present findings of the audits to the monthly Performance Improvement Committee for the next 3 months.</p> <p>5. The DON will ensure compliance</p>		

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F 279	<p>Continued From page 3</p> <p>6 hours as needed for mild pain and/or fever</p> <p>* [REDACTED] 100 mg three times a day for pain</p> <p>* [REDACTED] 2.5 mg every 12 hours for pain</p> <p>* [REDACTED] 5 mg every one hour as needed for pain (BTP-biliary tract pain)</p> <p>* [REDACTED] 20 mg every one hour as needed for pain and dyspnea (difficulty breathing). The hospice physician further instructed "Hospice RN (registered nurse) may instruct to repeat dose and/or titrate by 0.25 ml (milliliters) (5mg) q (every) 30 min (minutes) to a maximum of 1 ml (20 mg) q 1 hr (hour) PRN (as needed)."</p> <p>The hospice pain care plan also had specific medications for treating constipation should the resident develop constipation, which is a common side effect of pain medications.</p> <p>On 8/7/13 a Physician's order (Hospice physician) indicated to adjust the [REDACTED] dosage because the resident was experiencing an increase in abdominal pain. The physician also changed nausea medication from as needed to a routine dose because of increased nausea and vomiting. The physician indicated that clarification was needed so as to eliminate any confusion related to titrating and symptom management. The physician also eliminated excess [REDACTED] orders to minimize confusion as to which order to utilize for the resident's pain.</p> <p>These clarification orders were not addressed in either pain care plans. The facility failed to integrate the two care plans so facility nursing staff and the hospice nursing staff were coordinating the necessary pain interventions for Resident #86.</p>	F 279			

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F 279	<p>Continued From page 4</p> <p>During an interview with the Director of Nursing (DON) on 8/13/13 at 11:15 am, revealed that the DON had met with hospice management to initiate a process to better integrate hospice services with facility services especially in the areas of nutrition and pain. The DON acknowledged that there should be a coordination of care between hospice and the facility.</p> <p>#2. Resident #46's medical record revealed the resident had diagnoses that included skin issues with the use of a wound vac on her right lower leg, high blood pressure, anemia, congestive heart failure (ineffective heart pumping), and edema.</p> <p>Resident #46's Physician Admit Orders dated <del>6/20</del>/13 indicated the resident was to receive Lasix 40 milligrams (mg) daily and Lasix 80 mg in the evening. Lasix is a diuretic used to remove excess water from the body.</p> <p>A review of the resident's care plans revealed the following:</p> <p>*Urinary Incontinence care plan dated 7/5/13-no interventions regarding the use of diuretic that can cause increased urine output and an increase in urgency.</p> <p>*Nutrition care plan dated 6/3/13-no documentation regarding the use of diuretic use and the potential for weight loss due to the removal of water from the body.</p> <p>*Activities of Daily Living care plan dated</p>	F 279			

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F 279	Continued From page 5 6/3/13-the care plan intervention included safety awareness; however, there was no indication of diuretic use and the increased urine output and an increase in urgency.  *Hypertension care plan dated 6/3/13-the care plan indicated that if the resident experienced edema to encourage the resident to elevate the affected area and that nursing staff should observe for edema. there was no documentation indicating the resident was receiving a diuretic medication.  The facility failed to initiate a care plan that addressed the use of a diuretic and the necessary care and services needed for a resident receiving a diuretic.  On 8/13/13 at approximately 2:00 pm, the DON and Resident Care Manager (RCM) #1 were interviewed regarding Resident 346's diuretic use. Both the DON and RCM #1 indicated that it would have been best practice for the nursing staff to have initiated a care plan that addressed the diuretic use.	F 279			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced	F 309	F 309 1. The care plan and care directives for Resident 35 were updated to reflect the current fluid restriction. Daily totals are recorded and assessed. A clarification order was obtained from the resident's nephrologists regarding the calcium and vitamin D restrictions. The care plan and care guides reflect the restrictions.  2. Residents on fluid restriction were identified and a new form was implemented that shows the physician ordered restriction. No other residents have physician orders for calcium or vitamin D restrictions.	9/24/13 ✓	

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F 309	<p>Continued From page 6</p> <p>by: Based on observation, interview, and record review, the facility failed to monitor fluid restrictions, Calcium and Vitamin D restrictions for one of one sampled resident (Resident #35) with chronic kidney disease.</p> <p>Findings include:</p> <p>Review of Resident #35's medical record revealed diagnoses that included chronic kidney disease- (advanced kidney damage with a severe decrease in kidney filtration), catheter (drains urine from the bladder. It is inserted into the bladder through ), diabetes, high blood pressure, and (impairment in movement and/or feeling ).</p> <p>A Nursing Note dated 7/24/13 at 6:35 pm indicated that the resident had returned to the facility from the hospital and her orders included 800 milliliter (ml) per 24 hour fluid restriction and no Calcium or Vitamin D products.</p> <p>A FAX ORDER REQUEST/NOTIFICATION FORM dated 7/24/13 to Resident's #35's physician asked the following, "1. May we resume previous diet: fluid restriction 800 mL/24hrs, No Calcium products or Vit D..." The physician's response was "all above except for fluid restriction. 800 mL does not sound right. Please fax me that order from [physician's name]." On 7/27/13, Resident #35's physician ordered a fluid restriction of 1000 ml/24 hours.</p> <p>1. Resident #35's current nutritional care plan</p>	F 309	<p>3. The DON educated licensed nurses (LNs) on the new fluid restriction form and the protocol for calculating and assessing daily intake. LNs were educated on following physician orders for dietary restrictions.</p> <p>4. RCMs will audit the fluid restriction forms at least weekly for not less than 3 months to ensure compliance with the new protocol. RCMs will audit physician orders to ensure dietary restrictions are followed. The DON will present findings of the audits to the monthly Performance Improvement Committee for 3 months.</p> <p>5. The DON will ensure compliance.</p>		

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F 309	<p>Continued From page 7</p> <p>dated 7/22/13 still indicated the resident was to receive 800 ml per 24 hour period.</p> <p>A binder at each Nurse's Station contained resident Care Directives, which indicated each resident's care needs (this information was used by the nursing assistants who provided care to the residents). Resident #35's Care Directive dated 8/13/13 (5:18 am) did not reflect the fluid restriction change to 1000 ml/24 hours. The current Care Directive still indicated 800ml/24hrs fluid restriction. Resident #35's Care Directive under the "Additional Information" section also indicated the resident could be non-complaint with the fluid restriction.</p> <p>On 8/13/13 at approximately 10:00 am, the Director of Nursing (DON) was present when the Intake/Output Records were reviewed. The records indicated that the nursing staff were not totaling the amount of fluid the resident was receiving each shift. The nursing staff was also not completing the "Weekly Intake and Output Evaluation" section at the bottom of each pre-printed form. The forms also did not indicate the total amount of fluids the resident should be currently receiving. The form for the week of 7/24/13 did not indicate a physician order had been received increasing the resident's fluid restriction from 800ml/24 hrs to 1000ml/24 hrs.</p> <p>The "INTAKE/OUTPUT RECORD" for the week of 7/24/13 reflected the following fluid totals:</p> <p>*7/25/13-800ml *7/26/13-580ml (800ml allowed) *7/27/13-640ml (physician's order received increasing the resident's fluid restriction to 1000ml/24 hrs</p>	F 309			

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F 309	<p>Continued From page 8</p> <p>*7/28/13-840ml (1000 ml allowed) *7/29/13-600ml (1000 ml allowed)</p> <p>The "INTAKE/OUTPUT RECORD" for the week of 8/7/13 reflected the following fluid totals:</p> <p>*8/7/13-560 ml (1000 ml allowed) *8/8/13-800 ml (1000 ml allowed) *8/9/13-800 ml (1000 ml allowed) *8/10/13-1020 ml (1000 ml allowed) *8/11/13-720 ml (1000 ml allowed)</p> <p>The facility's practice of not totaling the amount of fluids the resident was receiving demonstrated that the nursing staff was unaware of the total amount of fluids the resident was receiving each day. During this review, the DON indicated that the nursing staff should have totaled the amount of fluid the resident was receiving each day. The DON also acknowledged that the nursing staff should have been completing the "Weekly Intake and Output Evaluation" section on the preprinted "INTAKE/OUTPUT RECORD."</p> <p>2. Resident #35's current nutritional care plan dated 7/22/13 did not reflect the Physician's order for no Calcium or Vitamin D products from 7/24/13.</p> <p>A binder at each Nurse's Station contained resident's Care Directives, which indicated each resident's care needs (this information was used by the nursing assistants who provided care to the residents). Resident #35's Care Directive dated 8/13/13 (5:18 am) did not reflect that the resident was not to receive any calcium or Vitamin D products.</p> <p>Resident #35 was interviewed on 8/12/13 at 7:30</p>	F 309			

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F 309	Continued From page 9 am, the resident was in bed dressed in a nightgown. The resident was observed eating breakfast. The resident explained that her blood sugar was low that morning so the "nurse" brought her a glass of orange juice and a bowl of rice crispies with milk. The resident was eating the last of her cereal during the interview.  On 8/13/13 at approximately 10:30 am, the Dietary Manager (DM) was interviewed about Resident #35's restrictions. The (DM) indicated that the resident was on fluid restrictions. The DM indicated that the resident did not receive any fluids on her trays. The DM explained that nursing provided the resident with all her fluids. The DM also indicated the resident was not to receive any Calcium or Vitamin D products. The resident's restrictions were identified on the resident's tray card.  The resident should not have received milk for her cereal because milk contains Calcium. On 8/13/13 at approximately 10:30 am the DON was made aware of this observation. The DON acknowledged the resident should not have received the milk.	F 309			
F 318 SS=E	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION  Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318			

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F 318	<p>Continued From page 10</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure (Resident #s ( 83 and 104); 2 of 3 residents identified with decreased range of motion received appropriate treatment and services to prevent further decrease in range of motion. The facility demonstrated a system failure in communication between restorative department, therapy department, and nursing that placed all residents in the facility with decreased range of motion at risk for further decline.</p> <p>Findings include;</p> <p>1. During dining observation on 8/6/13 at 7:52 A.M., Resident #83 held his wrist turned inward with his index, middle, and ring fingers in hyperextension (extended fully) and the thumb turned inward to the palm. The resident did not move the fingers or left wrist. All fingers of the right hand appeared contracted and the hand was deformed. The resident's head was bent forward with his chin resting on his chest. Resident #83 did not raise his head during the meal.</p> <p>In an interview on 8/6/13 at 10:54 A.M. RCM1 reported Resident #83 had contractures of his neck and hands but could move his legs. A contracture was defined as a condition of fixed high resistance to passive stretch of a muscle. RCM1 said Resident #83 had a motor vehicle accident some years ago with a traumatic brain injury and the contractures resulted.</p> <p>Observation revealed Resident #83 sat in his wheel chair with chin down and head tipped forward onto his chest. He was not observed to</p>	F 318	<p>F318</p> <p>1. Resident 83 was reassessed by physical therapy and put back on a Restorative Nursing program for contracture management. A revised quarterly screen was done that reflects the current Restorative Nursing program,</p> <p>Resident 104 no longer resides in the facility.</p> <p>2. Residents who were transitioned from Level 2 to Level 1 in the past 3 months were reviewed by nursing and therapy to ensure appropriate range of motion is provided. Residents currently on a restorative nursing program were reviewed for program compliance. Any who were unable to participate were assessed to identify the cause and programs were adjusted as needed.</p> <p>3. The DON educated the Restorative Nurse (RN) on the</p>	9-24-13 ✓	

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F 318	<p>Continued From page 11</p> <p>lift his head or straighten out his neck during observations at 30-60 minute intervals over 3 days of observation 8/5/13 through 8/7/13. He leaned his head to the left. He did not "look up" to make eye contact for conversation. When in his room watching TV he sat with his hips at the front edge of the wheelchair seat and his shoulders on the back of the wheelchair. In this position he was able to see TV without bringing his head up away from his chest or tilting his head back. The resident declined to allow observation of his care. On 8/7/13 at 9:30 A.M., NAC 1 said she did not provide ROM to Resident #83; she said she gave care according to the care directive.</p> <p>Record review found a PT (physical therapy) progress report dated 8/16/12 that indicated Resident #83 had multiple contractures and skilled service (therapists) "designed and implemented a contracture management program. Caregiver education: RA (restorative aide) trained for ROM (range of motion); stretching of cervical/neck and trunk; Progress to treatment was limited due to increase tone, mm shortening, kyphosis (curved spine) and joint ankylosis (stiffening of joints); will benefit from RA daily easy stretching program to trunk to maintain patient current condition.</p> <p>The PT progress report included " Remarks: Demonstrated, instructed and educated RA on stretching program and the importance of maintaining current range of motion to trunk and neck, ie for eating, breathing, dressing and decrease pain. "</p> <p>In an interview on 8/9/13 at 11:00 A.M. RN1 said she was in charge of the restorative nursing program. She said restorative included</p>	F 318	<p>policies for the Restorative Nursing Program including:</p> <ul style="list-style-type: none"> <li>• Purpose of the program (maintain function, prevent decline)</li> <li>• Sources of nursing/therapy referrals (24 hour report, Quality Measure report, therapy screens, MDS assessments, etc)</li> <li>• Need to update care plans and care guides to reflect current restorative programs</li> <li>• Proper procedures for transitioning from Level 2 to Level 1 programs (training nursing assistants on specific Range of Motion exercises)</li> <li>• Need to modify programs if a resident is not able to participate.</li> </ul> <p>The Director of Rehab (DOR) in serviced therapists on the protocol for completing timely and accurate screens. Restorative meetings will be re-scheduled so the DON can attend. Residents transitioning from Level 2 to</p>		

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F 318	<p>Continued From page 12</p> <p>"exercises and various other things with residents to help maintain and enhance and progress flexibility." RN1 said B&amp;B (bowel and bladder), and social issues were also important. RN1 said the facility did some B&amp;B training, but she only recalled two lately with good bladder training plans.</p> <p>RN1 said residents got on a restorative program when the PT-OT (occupational therapy)-ST (speech therapy) rehab department referred the resident for extra exercises or mobility training or strengthening. LN1 said she did the assessments for the restorative nursing program. LN1 said the maximum number of residents for the program depended on how many residents were on restorative and how many programs each resident had and how long they took to do their exercises or program. RN1 said the facility staffed two restorative aides with coverage from 6:00 A.M. to 6:30 P.M. 7 days a week.</p> <p>RN1 said the residents got off the restorative program when they plateaued. When asked what plateaued meant. LN1 said "plateaued means they can manage the exercise on their own, or they are a level one; level one means they are independent in their exercise or they plateaued (don't improve anymore) and it is incorporated into their ADL care " LN1 said the regular nursing assistants provide ROM when the resident "goes off" restorative program. LN1 said, "The nursing assistants are ranging the residents when they put their clothes on". RN1 said level one was a nursing maintenance program. LN1 said the maintenance program was put on the care directives. LN1 indicated the current care directives were in a binder at each nurse station. RN 1 said the facility printed updated directives</p>	F 318	<p>Level 1 will be reviewed by the DON and DOR during the Restorative meetings to ensure appropriate nursing assistant training.</p> <p>4. The DON and DOR will review the Restorative program during the bi-monthly meetings. The DON will report issues of non-compliance with facility protocols to the monthly Performance Improvement Committee for not less than 3 months.</p> <p>5. The DON will ensure compliance</p>		

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F 318	<p>Continued From page 13</p> <p>each month and it was an expectation that nursing assistants used the directive as the guide or reference to know what care the resident required.</p> <p>When asked who monitored for decline after the resident went off restorative RN1 said Nursing monitored to be sure the resident was not declining in ROM. RN1 said "it obviously has to start with the nursing assistant, if they noticed a decline they would go to the nurse." LN1 said she did not receive any direct referrals from nursing; they came from the rehab department; 99.9% of referrals came through therapy. LN1 said nursing sometimes referred to therapy and then they referred to restorative.</p> <p>When asked about Resident #8 's restorative program. RN1 said he was not on a restorative program. RN1 said his program was a communication program with ST but he was non-participatory and he only made guttural sounds due to his TBI so he was put on level 1. RN1 said he came off restorative months ago in March or May 2013.</p> <p>When asked about Resident #83's neck contracture; RN1 said he has been that way as far as she has known. RN1 said he was not consistent and sometimes refused the ST program so ST dropped him and he has been on a program with nursing. RN1 said the program for nursing would be on the care directive.</p> <p>RN1 said restorative aides trained in a program down in Seattle and each time there was an unfamiliar exercise then the therapist did training for that particular exercise. RN1 said when a resident transitioned from restorative to nursing</p>	F 318			

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F 318	<p>Continued From page 14</p> <p>there was no training for the nursing assistants. RN1 said she considered it to be a part of basic care. RN1 said she had no special training to be the restorative nurse. RN1 said the facility had 24 residents on the restorative caseload as of 8/6/13.</p> <p>In an interview on 8/9/13 at 2:00 P.M. the DNS did not know which residents were on restorative nursing programs or had nursing level one programs. The DNS said a plateau in ability or in ROM was not an indication to remove a resident from a restorative program. The DNS said the restorative program was to maintain function as much as it was to improve function. The DNS said the therapy department screened all residents on a quarterly basis to monitor for decline. They screens were to be done on the same schedule as the comprehensive assessment. The medical record had no screen for Resident #83 since 10/23/12. The DNS said she would find more current screens. The DNS provided a screen dated 7/10/13 for Resident #83. The screen inaccurately indicated that Resident #83 was on a PT restorative program for cervical/neck and trunk and indicated the last time the resident was assessed was 8/20/12.</p> <p>In an interview on 8/9/12 at 1:45 P.M., the therapy manager (TM) said the facility held a restorative meeting twice a month to discuss the current caseload for restorative. TM said the attendees included herself, the restorative nurse, and the restorative aides. TM said they addressed things that needed changing. The DNS said she did not attend the restorative meetings and did not send a nursing representative.</p> <p>TM said residents were put on restorative</p>	F 318			

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F 318	<p>Continued From page 15</p> <p>programs when the nurse sent a referral to therapy. The TM said the therapists also made dining rounds and identified needs that way. When asked if residents ever went back on restorative programs after coming off a program, TM said "if they decline after coming off restorative, then the resident would possibly go back on restorative." The decline would be recognized during a screen. TM said every resident was screened quarterly; one therapist was in charge of the screen, then the other therapists read the screen and signed off on the screen. All three disciplines indicated whether the resident could benefit from skilled therapy." The only example of a resident going back on restorative they could think of was when a resident's splints did not fit right she went back on restorative and the therapists trained the restorative aides how to apply the splints. The TM acknowledged the routine nursing staff was not so trained. The TM acknowledged that the screen for Resident #83 dated 7/10/13 was signed by only one discipline and inaccurately indicated the resident was on a restorative program that was discontinued months prior.</p> <p>When asked about ROM exercises, TM said moving a resident's arms and legs to dress the resident did not constitute ROM. TM said the care plan should specify which joints are to be ranged and how far the joints should be moved.</p> <p>On 8/9/13 at 3:00 P.M. RN1 confirmed that the Care Directive contained no information about ROM or stretching exercises for Resident #83's neck and joints. Although PT specially trained the restorative aides to stretch and provide ROM for Resident #83's neck and joints the facility did not provide any such training to the regular nursing</p>	F 318			

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F 318	<p>Continued From page 16</p> <p>staff when the restorative nurse determined the resident no longer required restorative services. The restorative nurse was unaware that the information for nursing regarding stretching and ROM was not on the Care Directive and was not on the care plan in the medical record. RN1 said she did not put information on the care directives, she thought the nurse managers did.</p> <p>2. The restorative record indicated Resident #104 had a restorative program that included standing frame for 15 minutes or as tolerated and seniorcise exercise program for upper and lower extremity ROM exercises. The restorative record showed the resident did not receive the standing frame program for 12 consecutive days in the month of August 2013. The resident did not receive the standing frame program on August 3, 5, and 7, 2013 because the NACs (Nursing Assistant Certified) put the resident to bed before the RA was available for the program. The program was not completed on August 6 and 7 due to the resident was at an activity when the RA was available, the resident was too sleepy on August 9 and 10 when the RA was available and the program was not completed on August 2, 4, 5, and 8 due to second RA not available.</p> <p>A Restorative Summary Note written by RN1 dated 8/8/13 read in part; "Is able to tolerate the standing frame for up to 15 minutes however is exhibiting a gradual inability to bear own weight. Often Resident #104 has been put back to bed for rest before restorative program begins. Will follow progress on standing frame and modify as needed." The resident did not receive the standing frame program for at least eight consecutive days from August 1 through 8, 2013. The July 2013 restorative record was not</p>	F 318			

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F 318	Continued From page 17 available for review.  A nursing note dated 8/7/13 indicated the facility conducted an annual review for Resident #104 with staff interviews and review of nursing notes and therapy notes. The note indicated the resident participated in seniorise but needed frequent cues to remain awake and participate and indicated the care plan was updated.  A review of the Care Directive dated 8/7/13 for Resident #104 found no indication the resident received restorative nursing program, no indication to the staff to have the resident up and ready at a particular time for a program. There was no evidence of coordination between nursing and restorative regarding RA availability, nap times, and activity schedules to ensure Resident #104 was offered the opportunity to participate fully in the restorative program.	F 318			
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE  Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.  This REQUIREMENT is not met as evidenced by:	F 325	F325 1. Resident 46 no longer resides in the facility.  2. Weights were reviewed for other residents in the facility and no further issues were identified.  3. The DON educated RCMs and MDS nurses on care plan development and nursing documentation for residents	9-24-13 ✓	

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F 325	<p>Continued From page 18</p> <p>Based upon interview and record review, the facility failed to have a system in place to recognize, evaluate, and address potential weight loss for one of three sampled residents (Resident #46) reviewed for nutrition.</p> <p>Findings include:</p> <p>Resident #46's medical record revealed the resident had diagnoses that included skin issues on her right lower leg, high blood pressure, anemia, hypokalemia (a lower-than-normal amount of potassium in the blood), congestive heart failure (ineffective heart pumping), and edema.</p> <p>An Admission Minimum Data Set (MDS-Federally mandated assessment tool) dated 6/1/13 documented the resident's Brief Interview for Mental Status (BIMS) score to be an "8," which indicated moderate cognitive impairment. The assessment revealed the resident required supervision-oversight, encouragement, or cueing with eating. The documentation also indicated the resident was receiving a mechanically altered and therapeutic diet. The MDS history reflected the following weights: Admission MDS, 6/1/13--176 pounds (lbs), 14-day MDS, 6/8/13--165 lbs, and Discharge MDS, 6/21/13--155 lbs.</p> <p>A FAX ORDER REQUEST/NOTIFICATION FORM dated 6/6/13 indicated "[family member] mentioned Rsd [resident] has been on Lasix at home, @ 40 mg @ noon &amp; 80 mg in the morning. did not admit [with] lasix orders. Has +1 edema on LLE (lower left extremity) and +2 RLE (right lower extremity) around wound site. Do you want</p>	F 325	<p>with weight loss related to initiation of diuretic use.</p> <p>4. Weights will be reviewed at the weekly weight meeting and follow-up will include Registered Dietician (RD) referrals, nursing notes, and care planning. The DON will report results of the weekly reviews to the monthly Performance Improvement Committee.</p> <p>5. The DON will ensure compliance</p>		

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F 325	<p>Continued From page 19</p> <p>any lasix at this time." The resident's physician responded on 6/7/13, "Lasix 80 mg PO (by month) Q (every) AM and 40 mg PO Q noon." Lasix is a diuretic medication used to remove excess fluid from the body.</p> <p>A nutrition care plan initiated on 6/3/13 and last updated on 6/26/13 indicated the resident was at nutritional risk related to skin issues, diagnosis of moderate protein and calorie malnutrition, history of dehydration, diagnosis of dementia, recent urinary tract infection, and anemia. The goals of the care plan included that the resident would not sustain significant weight loss and be free of any signs and symptoms of dehydration. The intervention included the following:</p> <p>*Observe and report any signs and symptoms of malnutrition and significant weight loss to the physician</p> <p>*Weigh and observe results weekly</p> <p>A review of the resident's weights revealed the following:</p> <p>*6/5/13--165 lbs *6/15/13--155 lbs</p> <p>This represented a significant weight loss of 10 pounds (6%).</p> <p>Review of the nursing notes failed to reflect any documentation regarding the weight loss. There was no indication that the significant weight loss was recognized, evaluated, or addressed by</p>	F 325			

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F 325	Continued From page 20 facility staff.	F 325			
F 371 SS=C	<p>During an interview with the Director of Nursing (DON) and Resident Care Manager (RCM) #1 on 8/13/13 at approximately 2:00 pm both indicated that the diuretic use should have been part of the plan of care and best practice would dictate that documentation be made that reflected the connection between the initiated diuretic use and the weight loss.</p> <p>483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that food was stored, prepared, distributed and served under sanitary conditions. Failure to prepare, distribute and serve foods under sanitary conditions may contribute toward potential food borne illnesses.</p> <p>Findings include:</p> <p>During the Initial Tour of the Kitchen on 8/05/2013 at 12:05PM the following was observed:</p>	F 371			

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NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF SKAGIT VAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1462 WEST STATE ROUTE 20 SEDRO WOOLLEY, WA 98284</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	<p>Continued From page 21</p> <p>lack of monitoring of the temperatures for the high temperature dishwasher and dirty fans blowing on the clean dishes and in the food preparation area. In a concurrent interview with the individual responsible for ensuring the dishes were washed for that shift he stated the temperatures should be obtained and recorded before each meal service. Review of the Dish Machine Temperature Log revealed dishwasher temperatures had not been obtained for breakfast and lunch for 8/03/2013, 08/04/2013 and 8/05/2013. The grill guards of four fans were observed to be matted with a dark particulate substance. Two of the fans were blowing directly toward the clean dishes and clean meal service items and 2 more fans were blowing directly toward the stove and the steam table which holds the food prior to being served. Later, during an interview with the Food Service Manager she acknowledged the dishwasher on duty for the aforementioned dates was a relatively new hire and that the temperatures had not been obtained.</p> <p>During further investigation during the lunch meal service on 08/08/2013 revealed continued dirty fans and expired food items. Five of the 5 fans in the kitchen continued to have a grime like substance on the fan guards which was easily removable with a white paper towel. Two of the fans were still blowing toward the stove and steam table. One fan was blowing toward the food preparation area and two fans were still blowing toward the clean dishes and meal service items. During a concurrent interview with the dishwasher he acknowledged the dirty fans should not be blowing toward the clean items. Further observations of the walk in refrigerator revealed the grill guards of the fans circulating cold toward the foods within refrigerator were dirty</p>	F 371	<ol style="list-style-type: none"> <li>No residents were identified.</li> <li>Dietary staff has been reeducated on procedure for taking dishwasher temps.  The 5 fans in the dietary department have been cleaned including the walk in refrigerator fan grill guards.  The expired food in the Emergency Food Supply has been discarded.</li> <li>Dietary staff has been re educated by the Dietary manager on the dishwasher temperature log requirements and the cleaning schedule for the fans.</li> <li>A bi monthly and as needed cleaning schedule has been set up for cleaning of fans in the Dietary Department.  The Emergency Food Supply items will be rotated through the dietary department monthly.</li> <li>Dietary Manager/designee will audit dishwasher temperatures for any missed temperatures daily.  Dietary Manager will audit the cleaning of the fans.</li> </ol>	9-24-13 ✓	

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F 371	Continued From page 22 with a blackish grime like substance that could be removed with a white paper towel. The Food Service Manager acknowledge the all the aforementioned fans were dirty. Expired food items within the Emergency Food Supply consisted of twelve 46 ounce containers of prune juice (expired 02/16/2013), twelve 46 ounce containers of pineapple juice (expired 12/16/2012) and forty-eight 12 ounce cans of Carnation evaporated milk (expired 2/15/2013).	F 371	Dietary Manager will do an inventory of Emergency Food Supply and label foods that expire within a month.  Results of these audits will be presented at the monthly PI meeting for 3 months.  6. The Dietary Manager and Executive Director will ensure compliance.		
F 518 SS=F	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS  The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.  This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility did not ensure all employees were competent in use of the Kitchen Fire Suppression System and Fire Extinguishers. Failure to have staff knowledgeable on the use of the fire emergency equipment could lead to potential injury or harm to all the residents.  Findings include:  On 8/05/2013 during the Initial Tour of the Kitchen two fire extinguishers were observed in the kitchen. One red extinguisher and a silver extinguisher for grease fires. A Fire Suppression System was observed above the stove and oven and it could be activated by a wall mounted fire	F 518	F518  1. No residents were identified.  2. Dietary staff has been reeducated by the Dietary Manager on the fire procedures for the dietary department.  3. New "Kitchen Fire Extinguishing System" brochures have been hung by each fire extinguisher. Each extinguisher has been labeled as to its purpose.  4. Random mock fire drills and questioning will be done each month by Dietary Manager. Results will be presented at the monthly PI meeting for 3 months by Dietary Manager.  5. Dietary Manager and Executive Director to ensure compliance.	9-24-13 ✓	

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F 518	<p>Continued From page 23</p> <p>suppression activator key/switch.</p> <p>Prior to the lunch meal service on 08/08/2013 a Dietary Aide was requested to select the appropriate fire extinguisher to put out a grease fire and to verbalize to how to utilize the fire suppression system over the stove/oven. The Dietary Aide was unable to verbalize how the fire suppression system was activated nor was she able to articulate the purpose of the wall mounted fire suppression activator key/switch.</p> <p>On 08/09/2013 during the breakfast meal service the Cook and 2 Dietary Aides were requested, at different times, to select the appropriate fire extinguisher to put out a grease fire and to verbalize how to utilize the fire suppression system over the stove/oven. All three staff were unable to verbalize how the fire suppression system was activated nor were they able to articulate the purpose of the wall mounted fire suppression activator key/switch. One of the dietary staff members stated instead of using the silver fire extinguisher they would use the red fire extinguisher on a grease fire.</p>	F 518			